

When an organ transplant is the only method available to maintain life, and when there are more patients in need of transplantation than there are organs available, the selection of patients becomes literally a question of pronouncing a death sentence upon those to whom organ transplantation is denied.¹

Due Process in the Allocation of Scarce Lifesaving Medical Resources

Observers from numerous fields have been troubled by the difficulty of making life and death decisions in the allocation of scarce medical resources.² An important question for lawyers is whether the decision to deny a scarce medical resource calls for procedural safeguards. The effect of the due process clause³ in this area has yet to come under systematic scholarly or judicial scrutiny.⁴ Although one

1. Grad, *Legislative Responses to the New Biology: Limits and Possibilities*, 15 U.C.L.A.L. REV. 480, 497 (1968).

2. For example, a professor of psychiatry writes that in the "tragic area of fatal kidney disease . . . [t]he burden is not deciding who should be helped to live, but rather who should be left to die." Gorney, *The New Biology and the Future of Man*, 15 U.C.L.A.L. REV. 273, 313 (1968). In addition to the remarks of Grad (lawyer), *supra* note 1, and Gorney (psychiatrist), see the discussions (1) by ethicists: P. RAMSEY, *THE PATIENT AS PERSON* 239-75 (1971); Fletcher, *Dialogue between Medicine and Theology*, in *SHOULD DOCTORS PLAY GOD?* 150 (C. Frazier ed. 1971); Rescher, *The Allocation of Exotic Medical Lifesaving Therapy*, 79 ETHICS 173 (1969); (2) by sociologists: R. FOX & J. SWAZEY, *THE COURAGE TO FAIL* (1974); Simmons, Hickey, Kjellstrand & Simmons, *Family Tension in the Search for a Kidney Donor*, 215 J.A.M.A. 909 (1971); (3) by physicians: Calland, *Iatrogenic Problems in End-Stage Renal Failure*, 287 NEW ENG. J. MED. 334 (1972); David, *The Agony and the Ecstasy of the Nephrologist*, 222 J.A.M.A. 584 (1972); Farrow, Fisher & Johnson, *Dialysis and Transplantation: The National Picture over the Next Five Years*, 3 BRITISH MED. J. 686 (1972); and (4) by legal scholars: Calabresi, *Reflections on Medical Experimentation in Humans*, 98 DAEDALUS 387 (1969); Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation*, 15 U.C.L.A.L. REV. 357 (1968); cf. Reichsman & Levy, *Problems in Adaptation to Maintenance Hemodialysis*, 130 ARCHIVES OF INTERNAL MED. 859, 863-64 (1972) (description of the emotional difficulties of potential recipients of a scarce lifesaving resource).

3. "[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . ." U.S. CONST. amend. XIV. See *id.* amend. V.

4. There has been almost no discussion of due process in the medical area. One writer advocates that civil rights lawyers become involved in issues of medical rights, but admits:

[O]ne reason lawyers have not become involved in medical decision-making is that both they and their potential clients are unsure of how to approach the area analytically and thus how to determine when legal intervention is appropriate. Annas, *Medical Remedies and Human Rights: Why Civil Rights Lawyers Must Become Involved in Medical Decision-Making*, 2 HUMAN RIGHTS 151, 156 (1972). Another, proposing review procedures for the distribution of scarce medical resources, considers the possibility of review based upon constitutional grounds, but admits:

The latter . . . is included in the proposal not because I am aware of the existence of specific constitutional demands, but on the general principle that a legal process

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scarce device, the hemodialysis (or kidney) machine, has been subsidized under the 1972 amendments to the Social Security Act, a recent report of the Government Accounting Office indicates that not all who are entitled to treatment for chronic kidney failure are receiving it.⁵ The 1972 amendments reflect increased public concern in the area of scarce medical resources, but leave the underlying constitutional problem unresolved. If the development of new medical technology continues unabated, the problem of allocating scarce resources will become more acute.⁶

should never deprive its officers of the power to order that action be taken in compliance with the Constitution.

Katz, *Process Design for Selection of Hemodialysis and Organ Transplant Recipients*, 22 BUFFALO L. REV. 373, 400 (1973). See also Kutner, *Due Process of Human Transplants: A Proposal*, 24 U. MIAMI L. REV. 782, 798 (1970) (calls for due process in determining time of death).

Recently there have been a number of suits challenging the absence of procedural safeguards in decisions by hospitals to begin or terminate treatment of needy patients. These suits have resulted in interlocutory injunctions against denials of treatment and in settlements requiring the implementation of safeguards. None of these suits involved lifesaving benefits. See *Grein v. St. Paul Drug Rehabilitation Center*, 8 CLEARINGHOUSE REV. 45 (D. Minn. 1974); *Grasso v. Patch*, 7 CLEARINGHOUSE REV. 748 (D. Mass. 1974) (plaintiff methadone patients agreed to a dismissal of their due process challenge to termination of treatment; defendant administrators agreed to adopt regulations affording notice and right to counsel, to present witnesses and to testify); *Hileman v. Duval County Hosp. Authority*, 7 CLEARINGHOUSE REV. 490 (M.D. Fla., filed Nov. 1973) (challenge by residents of Duval County to a denial without a hearing of medical care by defendant public hospital for "administrative reasons" was settled when defendants established a hearing procedure); *Ramirez v. Los Angeles County Dep't of Health Serv.*, 8 CLEARINGHOUSE REV. 109 (Cal. Super. Ct. 1974) (plaintiffs won a preliminary injunction preventing defendant from terminating them from methadone treatment without a prior hearing; defendant was ordered to adopt procedures for appealing termination decisions and to provide notice of procedures). See also Rose, *General Practice Complaints—Case for a Patient's Advocate*, 122 NEW L.J. 774, 775, 788 (1972); Note, *Unnecessary Surgery: Doctor and Hospital Liability*, 61 GEO. L.J. 807, 831-32 (1973).

5. For a description of the hemodialysis machine, see note 37 *infra*. The 1972 amendments to the Social Security Act, 42 U.S.C. § 426(e)-(g) (1974), Pub. L. No. 92-603, § 299, 86 Stat. 1463-64, made funds available to those eligible for Social Security benefits for hemodialysis and kidney transplants.

According to COMPTROLLER GENERAL OF THE UNITED STATES, REPORT TO THE CONGRESS: TREATMENT OF CHRONIC KIDNEY FAILURE: DIALYSIS, TRANSPLANT, COSTS, AND THE NEED FOR MORE VIGOROUS EFFORTS (HEW June 24, 1975) the 1972 amendments do not effectively alleviate the scarcity of these lifesaving resources. First, doctors frequently do not refer to treatment centers all those entitled to dialysis or transplants. *Id.* at 12-15. Moreover, officials of dialysis centers continue to exclude potential recipients from treatment on various medical and social grounds, although in theory there is no financial impediment. For example, some centers which provide only home dialysis, exclude applicants they believe lack the "medical and psychological stability," "motivation," or adequate home facilities to undergo treatment. *Id.* at 16-17. Finally the report points out that by their terms the Social Security amendments leave substantial financial burden on the patient. *Id.* at 49-50, 53.

6. The problem of scarcity is apt to arise with particular force in the area of artificial hearts. Given the present technology, it has been estimated that such devices will become available within 10 years. THE ARTIFICIAL HEART ASSESSMENT PANEL OF THE NATIONAL HEART AND LUNG INSTITUTE, THE TOTALLY IMPLANTABLE ARTIFICIAL HEART 37 (1973). Because heart dysfunction is widespread, a long period during which potential recipients will be denied the device must be anticipated. See *id.* at 41-45.

Another area of impending scarcity is the treatment of hemophilia. If prophylaxis (at present the most effective treatment of severe hemophilia) were to be given to only those who suffer from severe hemophilia, over 13,000,000 units of whole blood would

This Note will explore the extent to which due process is required in decisions by hospitals to withhold the benefits of scarce lifesaving treatment. The Note will argue (1) that since a substantial proportion of hospitals are government owned and operated, and most remaining hospitals have important connections with government, there is sufficient state action to make the due process clause applicable; (2) that denial of treatment is a deprivation of life within the meaning of the due process clause; and (3) that established procedures, which leave room for arbitrary and discriminatory decisions, are constitutionally invalid.⁷ The Note then suggests procedures that might satisfy the requirements of due process.

I. The Requirement of Due Process in the Allocation Decision

A. State Action

Decisions to grant or deny a scarce lifesaving resource are typically made by committees or individuals acting on behalf of the hospital.⁸ Due process is required only if these decisions can be considered acts of the state.⁹ State action is generally present if the institution is publicly owned and operated—*i.e.*, a federal, state or municipal hospital—at least in acts carried out on behalf of such hospitals by employees or other agents of the state in their official capacities.¹⁰ In the United States, approximately 38 percent of all hospitals, with approximately 54 percent of all hospital beds, are public.¹¹

be required. The number of units collected for that purpose in 1971 was approximately 9,000,000. Optimal treatment of severe cases alone would therefore require 4,000,000 more units than are presently available. See NATIONAL HEART AND LUNG INSTITUTE, BLOOD RESOURCE STUDIES 29, 127 (summary vol., Nat'l Institute of Health 1972). Failure to receive this optimal treatment may have a "crippling" effect on a patient suffering from severe hemophilia, but will not necessarily cause death. Interview with Dr. Jan Van Eys, Head of Pediatrics, M.D. Anderson Hosp. & Tumor Institute, Houston, Tex., June 6, 1975 (telephone).

7. The immediate purpose of this Note is to propose procedural standards for decisionmaking. It is not concerned with the content of decisions, but with the possibility of failure of the system to adhere to its own substantive standards (*e.g.*, the failure of a hospital, professing to give priority to those with the largest number of dependents, to ensure an accurate count of the dependents).

8. See pp. 1742-43 *infra*.

9. Due process is compelled by the Fifth Amendment where the federal government is involved and by the Fourteenth Amendment where state or local government is involved. The general term "state action" is used to refer to both forms of government involvement.

10. See *West Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 637 (1943) ("The Fourteenth Amendment . . . protects the citizen against the State itself and all of its creatures . . ."); *Hathaway v. Worcester City Hosp.*, 475 F.2d 701 (1st Cir. 1973).

11. U.S. DEPT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 77 (95th ed. 1974).

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The status of private hospitals is less clear. The general test of state action calls for a "sifting [of] facts and weighing [of] circumstances" to determine whether the state has "so far insinuated itself into a position of interdependence [with a private owner] that it must be recognized as a joint participant in the challenged activity"¹² There are many private hospitals in which the government participates significantly in ownership and operation. This may in itself be sufficient to establish the presence of state action in those activities of the hospital which affect the public.¹³ And all hospitals, even those which are purely privately owned and operated, are subject to general government regulation and receive widely distributed government assistance. Especially because hospitals perform what some courts describe as a "public function,"¹⁴ the receipt of federal Hill-Burton funds for hospital construction¹⁵ and receipt of Medicare and Medicaid funds¹⁶ may be sufficient ties to government to establish a position of "interdependence" with the state.

Some activities of a hospital may involve state action while others do not.¹⁷ The test of "interdependence" must be applied to the specific

12. *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722, 725 (1961), *cited in* *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974) and *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 172 (1972).

13. For example, state action was established where roughly half of the members of the hospital's board of governors were by charter responsible to, or were themselves, public officials and 14 percent of its budget was derived from public funds. *Chiaffitelli v. Dettmer Hosp., Inc.*, 437 F.2d 429 (6th Cir. 1971). Or the hospital may receive substantial government appropriations or be built on government land. *Eaton v. Grubbs*, 329 F.2d 710 (4th Cir. 1964).

14. *Compare* *Meredith v. Allen County War Memorial Hosp. Comm'n*, 397 F.2d 33, 35 (6th Cir. 1968) (characterizing normal hospital activity as a "public function" in finding state action) *with* *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 175 (1972) (refusing to find state action where the lodge was not open to the public). *See also* *Eastern Ky. Welfare Rights Organization v. Simon*, 506 F.2d 1278, 1288 (D.C. Cir. 1974) (holding that private nonprofit hospitals are "charitable" for tax purposes, even if they do not provide free services, because they do serve a community function).

15. 42 U.S.C. §§ 291-291o-1 (1974). The first case to base a finding of state action for private hospitals on Hill-Burton funding was *Simkins v. Moses H. Cone Gen. Hosp.*, 323 F.2d 959 (4th Cir.), *cert. denied*, 376 U.S. 938 (1963) (racial discrimination). While not all hospitals receive such funds, all are located in "Hill-Burton states" (telephone interview with Donald Sylvain, Division of Facilities Development, HEW, Apr. 3, 1975). Thus all are subjected to Hill-Burton regulations, another factor in favor of finding state action. *Eaton v. Grubbs*, 329 F.2d 710 (4th Cir. 1964). The scope of the Hill-Burton Act has recently been enlarged by the National Health Planning and Resources Development Act, Pub. L. No. 93-641 (Jan. 4, 1975).

16. 42 U.S.C. §§ 1395-1395ll (1970) and 42 U.S.C. §§ 1396-1396g (1970) respectively. *See* 2 T. EMERSON, *POLITICAL AND CIVIL RIGHTS* 2191-92 n.3 (3d ed. 1967). *But see* *Watkins v. Mercy Medical Center*, 364 F. Supp. 799, 802 (D. Idaho 1973) (pointing out that these funds are not tied to state-imposed policy constraints). *Watkins* overlooks the fact that the government, through these funds, uses hospitals to assist in a public function, i.e., ensuring that all citizens are provided with health care. Likewise, passage of national health insurance legislation would strengthen a finding of government action. *Cf.* S.3, 94th Cong., 1st Sess. (1975) (Sen. Kennedy's proposal for national health insurance).

17. *See* cases cited in note 19 *infra*. *Cf.* *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350-51 (1974) (public utility).

activity in question here—the allocation of scarce medical resources. To the extent that the state is involved at all in the operations of a hospital, its involvement is in support of the hospital's ultimate function of promoting the public health.¹⁸ Lower federal courts have found state action in various arbitrary and discriminatory practices by hospitals in which the state was no more implicated than in the allocation of medical resources,¹⁹ and have accepted the idea that state action should more readily be found where the challenged function bears on "a concern touching health and life itself."²⁰

Thus for the substantial sector of the nation's medical institutions comprised of public hospitals, state action is clearly present and procedural safeguards are required. While the presence of state action in the allocation of scarce lifesaving resources by private hospitals is not beyond question,²¹ it is at the very least a valid hypothesis. Should

18. There are indications of a congressional intent to ensure the adequate distribution of medical resources. *See, e.g.*, 42 U.S.C. § 291(a) (1970), the "purpose" clause of the Hill-Burton Act, which provides federal construction funds through state channels in order to

assist the several States in the carrying out of their programs for the construction and modernization of such public or other nonprofit community hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic or similar services to all of their people.

(Emphasis added.) *See also* 42 U.S.C. 1395(c) (1970) (Medicare) and 42 U.S.C. 1396 (1970) (Medicaid).

19. *See* *Christhilf v. Annapolis Emergency Hosp. Ass'n*, 496 F.2d 174 (4th Cir. 1974) (state action where hospital terminated privileges of physician without a hearing); *Sams v. Ohio Valley Gen. Hosp. Ass'n*, 413 F.2d 826 (4th Cir. 1969) (state action where hospitals denied staff appointments and privileges to physicians practicing outside county); *Meredith v. Allen County War Memorial Hosp. Comm'n*, 397 F.2d 33 (6th Cir. 1968) (state action where hospital allegedly denied physician reappointment without hearing and notice); *Cypress v. Newport News Gen. & Nonsectarian Hosp. Ass'n*, 375 F.2d 648, 651 & n.3 (4th Cir. 1967) (state action where hospital denied application for staff membership by black physician); *Smith v. Hampton Training School for Nurses, Inc.*, 360 F.2d 577 (4th Cir. 1966) (state action where hospital discharged nurses protesting racial segregation); *cf. Citta v. Delaware Valley Hosp.*, 313 F. Supp. 301, 306-08 (E.D. Pa. 1970) (state action where hospital restricted privileges of physician based on performance) (dictum).

However, courts may find no state action where the hospital activity in question is affected by religious scruples or is a matter of internal management in the absence of invidious discrimination. *See, e.g.*, *Ascherman v. Presbyterian Hosp. of Pac. Medical Center*, 507 F.2d 1104 (9th Cir. 1974) (termination of physician's staff privileges not state action); *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308, 312-14 (9th Cir. 1974) (denominational hospital's refusal to perform sterilization because of religious and moral scruples not state action). *See also* *Jackson v. Norton-Children's Hosp., Inc.*, 487 F.2d 502, 503 (6th Cir. 1973); *Doe v. Bellin Memorial Hosp.*, 479 F.2d 756, 761-62 (7th Cir. 1973) (Fourteenth Amendment does not prevent hospital from denying facilities for abortions); *Ward v. St. Anthony Hosp.*, 476 F.2d 671, 675 (10th Cir. 1973) (Fourteenth Amendment does not prevent discharge of physician from staff); *Mulvihill v. Julia L. Butterfield Memorial Hosp.*, 329 F. Supp. 1020, 1023 (S.D.N.Y. 1971).

20. *Simkins v. Moses H. Cone General Hosp.*, 323 F.2d 959, 967 (4th Cir. 1963).

21. *See* cases cited in note 19, *supra*. Although some commentators have asserted the presence of state action in private hospitals (*see, e.g.*, 2 T. EMERSON, POLITICAL AND CIVIL RIGHTS 2191 n.3 (3d ed. 1967)), the recent Supreme Court decision in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974), weakens their assumption. In *Jackson*, plaintiff sued a private Pennsylvania utility company to enjoin the termination of her electric service without a hearing. Plaintiff's claim of state action rested on the company's extensive regulation by the state, its status as a government-protected monopoly, and the

that hypothesis prevail, it is important to determine its constitutional implications, *i.e.*, what process is "due." Even if only public hospitals are subject to constitutional requirements, private hospitals may well want to adopt procedural standards similar to those suggested in this Note.²²

B. *Deprivation of Life*

Those denied access to scarce lifesaving resources will die as a result; the question is whether this constitutes a deprivation of life within the meaning of the due process clause. An essential rule established by the Supreme Court provides that "[w]hether any procedural protections are due depends on the extent to which an individual will

fact that it provided an essential public service. *Id.* at 351-53. The Court held these factors insufficient, reasoning that the general regulation did not amount to a sufficiently close nexus between the state and the company. *Id.* at 353. The Court distinguished *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961) (holding racial discrimination by a private restaurant within a public parking building to fall within "state action") on its facts, finding no "symbiotic" relationship between the state and defendant. *Jackson v. Metropolitan Edison Co.*, *supra* at 357-58.

The reasoning in *Jackson* does not preclude a finding of state action for private hospitals receiving government aid via Hill-Burton and other typical government assistance and regulation. First, unlike the defendant in *Jackson* such hospitals are funded as well as regulated by the government. *Cf. id.* at 357. The public-private relationship is arguably "symbiotic"; the aim of Hill-Burton construction money is to ensure that there are enough medical care facilities for everyone, *see* note 18 *supra*. The government's scheme relies on private efforts to carry out the administrative tasks, without which construction funds could not serve their purpose. *See Burton v. Wilmington Parking Authority*, *supra* at 717, 723-24. Second, and more important, is the special nature of the public function which hospitals perform. In *Jackson*, the Court recognized as a principle governing the reach of the Fourteenth Amendment that "differences in circumstances beget differences in law." 419 U.S. at 358. The Court there declined to find that the public function of supplying electricity rose to the level of state action because the service was one which the state never obliged itself to supply. *Id.* at 353. In contrast, states invariably supply public medical facilities, independent of or complementary to existing private facilities. While the Court suggests that the public function should also be one traditionally associated with sovereignty, *id.*, and that occasional government provision of the service may not be sufficient, *id.* at 354 n.9, these suggestions should not relieve medical institutions of a finding of state action. The relevant consideration should be whether providing medical services can be considered a state function today. Moreover, to exempt private hospitals from state action would not serve to promote individual choice (unlike the Court's example of private schooling, where a state action standard might limit constitutionally protected choices). *See id.* at 354 n.9; *id.* at 372 (Marshall, J., dissenting). A final distinction is that in hospital activity, unlike the functioning of utilities, there is no intermediate regulatory agency (except the hospital itself) between the state and the recipient of services which can oversee the implementation of state policies. Regulatory authority has arguably been "delegated" to hospital administrators, who therefore should be considered agents of the state. *See generally* Note, *Fourteenth Amendment Due Process in Terminations of Utility Services for Non-payment*, 86 HARV. L. REV. 1477 (1973).

22. Public policy does not require that the procedures employed by public and private hospitals be the same. Application of constitutional requirements to public hospitals alone would provide a body of experience for private hospitals to consider. They may decide to adopt the constitutional procedures voluntarily, or to experiment with other procedures which might eventually be shown to strike a more favorable balance between costs and benefits than those safeguards which the courts would presently be willing to require.

be 'condemned to suffer grievous loss.'"²³ Someone whose very life depends on access to scarce medical resources surely meets this standard, particularly since an individual denied access to treatment by one hospital is often not able to obtain equivalent treatment from another.²⁴ One might argue that access to a highly specialized life-saving device is pure "bounty," a "mere" privilege. But recent cases have repudiated the distinction between "privileges" and "rights" as a basis for establishing a requirement of due process.²⁵

Whether there is a "deprivation" within the meaning of the due process clause depends in part on how strong and how justified are the expectations of the person affected by an adverse decision.²⁶ In the case of scarce lifesaving resources, an individual can justifiably expect a hospital not to deny him those resources without a reason. Both legislative policy²⁷ and the medical profession²⁸ avow an intent to distribute health care as widely as possible. Even without such an acknowledged purpose, the widespread public understanding that the medical profession is committed to such ends might well justify the expectation of being eligible for lifesaving treatment.²⁹ People can

23. *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972), quoting *Joint Anti-Fascist Refugee Comm. v. McGrath*, 341 U.S. 123, 168 (1951) (Frankfurter, J., concurring); *Goldberg v. Kelly*, 397 U.S. 254, 263 (1970).

24. An individual is generally dependant upon a single institution for scarce medical resources since illness creates time pressure, and individuals lack access to information about other sources of treatment. Large geographical areas often depend upon a single hospital and there may be prohibitive costs involved with seeking treatment outside one's area.

25. *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972), quoting *Graham v. Richardson*, 403 U.S. 365, 374 (1971); *Board of Regents v. Roth*, 408 U.S. 564, 571 n.9 (1972).

26. Compare *Board of Regents v. Roth*, 408 U.S. 564, 573-77 (1972) (state college non-tenured professor whose one-year contract had ended held not entitled to procedural safeguards in the determination of whether a new contract should be offered to him) with *Perry v. Sindermann*, 408 U.S. 593, 601 (1972) (college professor with similar claim established the basis for a finding of de facto, although not formal, tenure, which entitled him to due process protections in the determination of whether to grant a new contract). Note that in *Roth*, the Court stated that, if there had been a showing of "substantial adverse effect" upon the career of the professor, it might have resolved the case differently, but that a record indicating merely that the individual would be left "somewhat less attractive" by this discharge was insufficient to establish "deprivation of 'liberty.'" *Board of Regents v. Roth*, *supra* at 574 n.13. See also *Arnett v. Kennedy*, 416 U.S. 134, 151-58, 164-71 (1974) (three Justices in the plurality held that appellee's job was not elevated to a "property interest" because of limitations on tenure in enabling statute; two concurring Justices recognized a property interest, but one sufficiently protected by a hearing subsequent to job termination).

27. See notes 15, 18 *supra*.

28. Oaths taken by individuals entering the medical profession support an understanding by society that members of the profession will not favor one individual at the expense of another for arbitrary or discriminatory reasons. See, e.g., oaths quoted in Goodfield, *Reflections on the Hippocratic Oaths*, 1 HASTINGS CENTER STUDIES 79, 84 (1973); Guthrie, *Early Greek and Roman Medicine* in 11 ENCYCLOPEDIA BRITANNICA 826, 827 (15th ed. 1974). Belief in individuals' entitlement to the treatment itself is revealed by current proposals for compensation of persons faced with severe medical crises. See S. 2513, 93d Cong., 2d Sess. (1973) (Sen. Long's Catastrophic Health Insurance and Medical Assistance Reform Bill, now pending before the Senate Finance Comm.).

29. Cf. *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972).

legitimately expect both the state and the medical profession to make an effort to keep them alive.³⁰

Whether the grant of a benefit is a bounty—a “unilateral expectation”³¹—or a “legitimate claim of entitlement”³² depends ultimately on how vital is the interest at stake.³³ The state has been held to have “deprived” one of a protected interest when denying a request for a benefit in cases involving distribution of housing³⁴ and other benefits less vital than access to lifesaving medical resources.³⁵ If the requirement of due process ever applies to the grant of a benefit, access to scarce lifesaving treatment would seem to call most strongly for this protection. The denial of such an interest entails the ultimate loss; the customary and legitimate expectations are extremely high.³⁶

II. A Case Study in Inadequate Procedures

The scarcity of a medical resource is apt to be most acute when the underlying technology is both new and expensive. One of the

30. See JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, STANDARDS FOR ACCREDITATION OF HOSPITALS PLUS PROVISIONAL INTERPRETATIONS 45 (1969) (providing that: “Adequate appraisal and advice or initial treatment shall be rendered to any ill or injured person who presents himself at the hospital.”). Emergency room treatment is a subject of reasonable reliance under this analysis. A tort of omission has been found where a hospital maintaining emergency facilities “refuse[s] . . . service in case of unmistakable emergency.” See, e.g., *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 25, 174 A.2d 135, 140 (1961).

31. *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972).

32. *Id.*

33. The Court in *Roth* reasoned that the extent of an individual’s legitimate expectation was largely determined by the magnitude of the interest at stake and how irrevocable the loss if the interest were denied. See *id.* at 573-74. Thus, although the petitioner lost in *Roth* (in part on the grounds that he had no reason to expect his contract would be renewed and that he could probably find another job, see *id.*), the very same reasoning might well justify a requirement of procedural safeguards in the case of one applying for scarce lifesaving resources.

34. See *Holmes v. New York City Housing Authority*, 398 F.2d 262, 264 (2d Cir. 1968) (affirming the district court’s denial of a motion to dismiss complaint by rejected applicants for housing who alleged lack of notice of regulations on admissions, lack of a systematic process for approving applications, lack of any way to gauge the progress of one’s case, and, if and when ineligibility was decided, lack of notification thereof or of the reasons for it); *Joy v. Daniels*, 479 F.2d 1236 (4th Cir. 1973) (public housing tenants threatened with eviction have right to a hearing even after their lease expires).

35. See *Sosa v. Board of Managers of Val Verde Memorial Hosp.*, 437 F.2d 173 (5th Cir. 1971) (application for admission to the medical staff of a hospital could only be denied on grounds which were reasonably related to operation of the hospital, and due process required giving the applicant an opportunity to contradict or explain facts which might lead the defendant Board to reject him); *Hornsby v. Allen*, 326 F.2d 605 (5th Cir. 1964) (due process required in granting of liquor licenses; no valid distinction between the denial of an application and the revocation of a license); *Harnett v. Board of Zoning, Subdiv. & Bldg. Appeals*, 350 F. Supp. 1159 (D.V.I. 1972) (due process requires notice of standards for decision where zoning board approves development plans).

36. The Supreme Court has recognized that customary understandings may be as valid a source of constitutional rights as statutes. See *Perry v. Sindermann*, 408 U.S. 593, 599-603 (1972). Such a principle makes sense especially in light of the fact that the fortuitous of history have led some kinds of social welfare to be provided privately by professions and others to be provided publicly by legislative or other governmental mandate.

most widely publicized lifesaving devices in recent years has been the hemodialysis machine.³⁷ Starting in 1973 large government subsidies made hemodialysis machines more widely available; but the methods of allocation of these devices prevailing before 1973 are the best illustration of how medical institutions handle life and death decisions compelled by scarcity.³⁸

The possibility of arbitrary and inaccurate decisionmaking is exemplified by the procedures followed by two public institutions—the Los Angeles County General Hospital and the San Francisco General Hospital—in determining access to hemodialysis. In a 1967 account, the director of the California State Department of Health described four junctures at which an individual might be denied access to treatment:³⁹ (1) the patient's physician had discretion to decide whether or not to refer the patient to the hemodialysis program of the medical center;⁴⁰ (2) the medical director of the program had discretion to decide whether to place the individual in the pool of people to be evaluated at the medical center; (3) medical evaluators at the center were called upon to make a finding of "medical suitability"; and (4) a patient selection committee including lay people made a finding of worthiness for treatment "from an overall standpoint."⁴¹ Empirical studies report that similar patterns prevailed in the allocation practices of private institutions.⁴²

The decisions by medical directors whether or not to include an individual in the pool from which recipients of services would be

37. The hemodialysis machine performs the function of a kidney—cleansing the blood of toxic elements—for individuals whose kidneys have ceased to function. Through regular treatments an individual can be kept alive; without treatment he or she will die of kidney failure within roughly three weeks. In the late 1960's an estimated 7,000 people died every year for lack of such treatment. Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620, 636-37 (1969).

38. See note 5 *supra*. For a survey of the processes of scarce medical resource allocation in the late 1960's, see Note, *supra* note 37, and records of empirical study by the author of that Note, including interviews with hospital administrators and records of allocation committees, on file at the Columbia Law Library. While the scarcity of kidney machines has been partly alleviated by measures like the 1972 amendments to the Social Security Act, see note 5 *supra*, medical institutions will almost surely have to deal with serious scarcities in the future. See note 6 *supra*.

39. Breslow, *Public Health Report*, 107 CALIF. MED. 360 (1967), cited in Sanders & Dukeminier, *supra* note 2, at 367.

40. This step, which does not involve acts of the hospital, is beyond the scope of this Note.

41. Breslow, *supra* note 39, at 360.

42. Note, *supra* note 37, at 635-62. In some hospitals, allocation was based on a first-come first-served or a lottery system with no allowance for medical or social criteria. See, e.g., A PHYSICIAN'S SYLLABUS FOR THE TREATMENT OF CHRONIC UREMIA 4-5 (R. Davidson & B. Scribner eds. 1967) [hereinafter cited as SYLLABUS]. Such procedures are well adapted to a selection with no underlying substantive standards. But they are consistent only with a refusal to adopt substantive standards. When substantive standards are desired for the allocation of scarce medical resources, such mechanical procedures lose their particular value.

chosen gave them in effect a preliminary veto over further consideration of a patient.⁴³ The directors might be governed by articulated priorities (e.g., an upper age limit) or by informal priorities not openly stated.⁴⁴ The selection of the ultimate recipients of treatment by medical and lay committees then proceeded according to standards chosen by the hospital, which might include the following:

- 1) Medical suitability;
- 2) Psychological and sociological suitability, e.g., motivation to live, cooperation, or absence of obvious psychosis;
- 3) Social worth (this judgment was often left to the unguided discretion of the committee, or it might be guided by standards such as rehabilitative potential, manifest desire to live and enjoy life, "moral value," vocational history, intelligence, family status);
- 4) Mechanical procedures, e.g., lottery or first-come first-served.⁴⁵

The risk of arbitrariness, discrimination, and mistake grew out of a number of procedural inadequacies in the practices just detailed. 1) *Lack of notice*. Applicants were not necessarily aware of the fact that they were being considered for exclusion or selection, nor were they necessarily informed of the criteria governing the judgments.⁴⁶ 2) *Absence of a hearing*. Applicants were accorded no opportunity to present facts in their favor. Nor would the opportunity to be heard have been useful without notice of the criteria followed by the committees.⁴⁷ 3) *Variability of forum for decisionmaking*. Because there were several preliminary stages in the selection processes, some applicants were excluded from committee consideration, whereas others were not. In the absence of procedural safeguards, the preliminary "exclusions"⁴⁸ by the medical directors may have had the effect of dooming patients which the committees would have saved, even if the decisions by the directors and the committees were ostensibly made according to the same standards. 4) *Lack of guarantee of a fair tribunal*. There was no check on the composition of committees to ensure against bias.

43. See Note, *supra* note 37, at 654.

44. *Id.* at 639-54.

45. See SYLLABUS, *supra* note 42, at 3-5, 8, 9; Sanders & Dukeminier, *supra* note 2, at 366-80; Note, *supra* note 37, at 647, 655.

46. SYLLABUS, *supra* note 42, at 4-5; David, *supra* note 2, at 584.

47. Of course this does not mean that an aggressive patient or one with a well-connected physician could not arrange to ensure that all pertinent facts be favorably presented. In general, however, it is likely that important facts in many patients' favor will not come out and possible that facts will be distorted in a negative way by the depressing influence of sickness and hospitalization on the behavior and attitudes of some patients.

48. "Exclusion" is the term used in Note, *supra* note 37, at 654-57, to describe the initial decision to keep a patient out of the pool from which recipients of treatment will ultimately be selected.

5) *Lack of notification of the decision and its grounds.* Those who were rejected were not necessarily told the fact and why. This effectively prevented them from seeking some kind of review or opportunities for treatment elsewhere. Taken together, these inadequacies created a possibility that decisions by hospitals would be arbitrary or discriminatory.

III. What Process is Due?

A. *Evaluating Costs and Benefits*

As Justice Frankfurter wrote, due process "is not a technical conception with a fixed content unrelated to time, place and circumstances . . . [but] a delicate process of adjustment . . ."⁴⁹ The protections which are due should reflect both the magnitude and the nature of the interest at stake (access to scarce lifesaving resources) as well as the "costs"⁵⁰ of interfering with other priorities.⁵¹ The Supreme Court follows the general rule that

consideration of what procedures due process may require under any given set of circumstances must begin with a determination of the *precise nature of the governmental function involved as well as of the private interest* that has been affected by governmental action.⁵²

Recent decisions of the Court in analagous situations provide some insight into what factors will bear on the allocation of scarce medical resources. They set out what the Court considers the minimum process due in cases where individual interests of lesser magnitude than life are at stake.⁵³ Recent cases also identify various costs, including ex-

49. *Joint Anti-Fascist Refugee Comm. v. McGrath*, 341 U.S. 123, 162-63 (1951) (Frankfurter, J., concurring).

50. The term "costs" refers to disadvantages both of a pecuniary and nonpecuniary nature.

51. It should be stressed that *procedural* safeguards are the only concern here; the content of underlying substantive standards is beyond the scope of this analysis.

52. *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972) (emphasis added), *quoting* *Cafeteria & Restaurant Workers Union v. McElroy*, 367 U.S. 886, 895 (1961).

53. See *Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) (elaborate procedures justified on the ground that the benefits involved (welfare payments) were interests bearing on the "very means by which to live"); *Wolff v. McDonnell*, 418 U.S. 539 (1974) (prison disciplinary action); *Gagnon v. Scarpelli*, 411 U.S. 778 (1973) (probation revocation); *Morrissey v. Brewer*, 408 U.S. 471 (1972) (parole revocation). The following procedural requirements can be culled from the above cases:

1) An opportunity for a hearing tailored to the capacities and circumstances of those who are to be heard, *Goldberg v. Kelly*, *supra* at 268-69, and in conjunction with the hearing:

pense⁵⁴ and interference with the institution's pursuit of broader social goals.⁵⁵ The Court measures these costs according to the circumstances of the particular case,⁵⁶ and suggests that if circumstances change over time, the requirements of due process may change as well.⁵⁷

Since the "precise nature of the governmental [and institutional and social] function" must be considered, it will be impossible to fashion appropriate safeguards without going beyond existing cases, each one of which turns on its own factual context. A special problem in designing procedural safeguards for the allocation of lifesaving resources stems from the very scarcity of those resources, and calls for streamlined procedures. The expense of implementing due process may actually diminish access to the lifesaving treatment by using up funds that could be increasing the supply of treatment.⁵⁸ Therefore, the need

a) timely and adequate notice detailing the reasons for the proposed denial of benefits, *id.* at 267-68;

b) sufficient information as to the criteria on which decisionmaking will be based, *id.* at 269;

c) an effective opportunity to defend by presenting affirmative evidence, and confronting and cross-examining witnesses, *id.*, unless the hearing officer specifically finds good cause for not allowing confrontation and cross-examination, Gagnon v. Scarpelli, *supra* at 786; Morrissey v. Brewer, *supra* at 489.

2) An impartial decisionmaker who has not participated in making the initial findings under review. Goldberg v. Kelly, *supra* at 271.

3) A requirement of counsel where the facts which would be controlling at the hearing are difficult to develop and where in the administrator's opinion it appears that the individual is not capable of speaking effectively for himself. Gagnon v. Scarpelli, *supra* at 790-91.

4) A record or digest of the hearing and its result, and a written statement indicating the reasons for the decision and the evidence relied on. *Id.* at 786; Morrissey v. Brewer, *supra* at 487; Goldberg v. Kelly, *supra* at 271.

Since the interest of a patient in remaining alive is greater than the interests involved in the above cases, the procedures there found mandatory ought to be implemented in the medical context in some form, unless the special offsetting costs are significantly greater or the usefulness of the safeguard is significantly less.

Of the procedures listed above, the hearing is "the fundamental requisite of due process." Goldberg v. Kelly, *supra* at 267, citing Grannis v. Ordean, 234 U.S. 385, 394 (1914). Unlike the hearing, the other safeguards require a more specific showing of usefulness. See Wolff v. McDonnell, *supra* at 566-67; Gagnon v. Scarpelli, *supra* at 786-88. If a court is unable to determine whether the incremental benefit of a specific procedure outweighs the costs, it may entrust its use, within suggested guidelines, to the discretion of the administrator. See Wolff v. McDonnell, *supra* at 569-72; Gagnon v. Scarpelli, *supra* at 790.

54. See Goldberg v. Kelly, 397 U.S. 254, 261 (1970) (asserting that a claim of expense "does not justify denying a hearing meeting the ordinary standards of due process").

55. See Wolff v. McDonnell, 418 U.S. 539, 561-63 (1974); Morrissey v. Brewer, 408 U.S. 471, 483 (1972) (safeguards can and should be devised in such a way that a proper domain for discretion is reserved).

56. In Wolff v. McDonnell, 418 U.S. 539, 561-63 (1974), the Court considered the possibilities that an adversary hearing in prison disciplinary proceedings would heighten antagonisms, perhaps induce retaliation, and thus interfere with prison goals of discipline and rehabilitation as well as safety of personnel. The weight of those costs led the Court to restrict procedural due process requirements.

57. See Wolff v. McDonnell, 418 U.S. 539, 571-72 (1974).

58. If allocation without substantive standards (*i.e.*, with mechanical standards, see note 42 *supra*) turned out to be so much cheaper than allocation *with* those standards that substantial additional resources could be financed by the difference in cost, it could even be argued that allocation procedures which employ substantive standards are a violation of due process.

for minimal procedures derives not merely from the normal considerations against burdening the state, but also from the nature of the protected interest itself.

Attendant to the allocation of scarce lifesaving resources are a number of other problems which affect the application of the established principles of due process: (1) *patient anxiety*; (2) *infringement of privacy*; (3) *waste of resources* (overly elaborate process could slow down allocation to such an extent that some patients die unnecessarily); and (4) *social anxiety* (public awareness of decisions about life and death may be unsettling, especially if the standards for decision vary from place to place).

B. *Recommendations*

The following discussion of safeguards is not intended as a detailed program, but rather as a basic framework for allocating lifesaving medical resources. This general outline reflects the prior cases, the special costs and benefits, and the need to remedy obvious defects in established practices.⁵⁹

1. *Hearing and Notice*

To guard against inconsistent decisionmaking, a unified hearing should replace the various multistep processes. Establishing the basic requirement of a hearing still leaves open the proper format of the hearing. First, to lessen the anxiety to waiting applicants, the standard procedures should not be unduly protracted. There should be limitations on the time between application and notice, between notice and hearing, and between hearing and decision. To further reduce anxiety, the applicant's opportunity to confront witnesses should remain within the discretion of the decisionmakers at the hearing.⁶⁰ The presence of the patient at the hearing need not always be required since a representative could take his or her place. The privacy of the patients can be safeguarded to some extent by not permitting outsiders to at-

59. For concrete recommendations, further empirical data is needed. A full and meaningful account of the costs and benefits in this area requires extensive study of the economics of resource development and distribution, of hospital administration, of government health administration, and of possible alternative methods for adapting quasi-adjudicative processes to a hospital setting or affording access to adjudicative forums outside the hospital. Moreover, a meaningful cost-benefit analysis would require substantial information about the physical, financial and emotional hardships created by the diseases in question. Recommendations of a specific nature should also be shaped by arguments of interested parties. If they have the opportunity to press their own arguments, the common law process will have a chance to make its contribution.

60. This discretion has been allowed in post-conviction prison proceedings for analogous reasons. See note 53 *supra*.

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tend. It might be desirable to allow the decisionmakers to exercise some discretion as to substantive criteria, since they may encounter situations to which the announced criteria do not effectively apply. In that case, the notice given to the applicants would have to reflect this possibility; any decision not arising under established criteria should be explained in a written opinion.⁶¹

The scarce resources should never be allowed to lie fallow because of delays in the selection process. Hospital administrators should have the responsibility of coordinating allocation procedures, and the prerogative of intervening in them to ensure that no one suffers as a result of protracted formalities.⁶²

2. *Impartial Decisionmaker*

It is a general principle of due process that there be no undue prior involvement of the decisionmaker with the case being decided.⁶³ Such prior involvement would be particularly distorting in the allocation of scarce lifesaving resources, where the number who can receive benefits is unrelated to the number who deserve them.⁶⁴

Since those who are denied treatment will die, allowing decisions by individuals who have prior involvement with the applicants creates the possibility of guilt, pressure, and favoritism. It may also be well not to assign doctors to the committees which decide on the allocation of treatment. Their medical expertise does not in itself bear on the kinds of decisions that committees are called on to make,⁶⁵ and might better be devoted to healing other patients.

3. *Representative*

Representation serves to mediate between individuals and the institutions making decisions about their rights. Individuals are unlikely

61. This discretion would not allow committees to defy established standards, but only to apply additional standards to unanticipated problems. Admittedly, to allow any discretion at all might invite abuse, and perhaps no ad hoc "solutions" should be allowed.

62. The danger of giving administrators such authority is that they might exercise it too liberally. But the possibility that intervention and demand for rapid decisions might cause mistakes in a limited number of cases should probably be tolerated, since the alternative of wasting already scarce resources seems worse.

63. See, e.g., *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970). Obviously, it would also be unacceptable to allow the systematic exclusion of racial or ethnic minorities. See, e.g., *Alexander v. Louisiana*, 405 U.S. 625 (1972).

64. Cf. *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970), where the Court indicated that functionaries in the welfare system who had had certain dealings with the recipient were not necessarily barred from participating in the decision on eligibility. But in that context there is less likelihood of prejudicial effect from emotional involvement and bias. Unlike medical decisionmakers, welfare personnel need not deny benefits to anyone they find needy.

65. See Veatch, *Generalization of Expertise*, 1 HASTINGS CENTER STUDIES 29 (1973).

to be familiar with decisionmaking processes; decisionmakers rely on information about such individuals which, if improperly presented or obtained, may foster distortions or inaccuracies.

Patients' representatives need not have had legal training; a social work background might be appropriate. There is an additional question whether such representatives could be members of the hospital staff or whether they should function independently of any hospital.⁶⁶ In any case, a single representative should not work on behalf of two competing applicants.

An additional area of concern is the nature of the representation appropriate for allocation hearings. The fact that such situations can be emotionally charged might argue against allowing the patient to be present at the hearing, and in any case he or she should have the option of being represented *in absentia*. Similarly, the representative could shelter the patient from the occasional harshness of committee procedures.⁶⁷ The style of deliberation at the hearing could be adversary (with the representative acting as an advocate, able to withhold facts unfavorable to his client)⁶⁸ or collegial (with the representative participating in the decision on the basis of full disclosure).⁶⁹ In either case, the overriding function of the representative would be to discover and present relevant facts and to make up for deficiencies in the ability of individual applicants to represent themselves.

4. *Record and Opinion*

Due process generally requires decisionmakers to produce a record of their proceedings and an opinion stating the facts and reasons relied upon.⁷⁰ The purpose is to enable individuals to ascertain that

66. If the caseworker is a member of the hospital staff, there would be the risk of insufficient detachment from institutional pressures and priorities. However, if representatives were outsiders to the hospital, their unfamiliarity with hospital procedures might impair their performance.

67. The representative will be familiar with the patient's background, and therefore in a position to explain the relevant procedures to the patient, without burdening the patient unnecessarily with details which might cause anxiety in the particular case.

68. To ensure their capacity to protect privacy, measures could be taken to bring representatives within one of the established evidentiary privileges. See generally MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE §§ 72-77, 87-97, 98-105, 313 (2d ed. E. Cleary 1972) (concerning privileges generally, the lawyer-client privilege, the physician-patient privilege, and the use of hospital records).

69. Requiring full disclosure of facts seems preferable. There is, to be sure, no such obligation on defense lawyers in the criminal system. But in medical allocation only a limited number of people can "win" their cases; therefore the withholding of information hurts competing applicants. The requirement of disclosure does not necessarily imply a collegial hearing. The representative can still influence the interpretation of the standards to be employed in the face of unfavorable facts.

70. See cases cited in note 53 *supra*.

their rights have been properly protected, and to provide a possible basis for recourse.⁷¹ In this particular area the advantages of providing a record, an opinion and a right of recourse must be judged against the disadvantages of inefficiency, patient anxiety, invasion of privacy, and—if such material were made available to the public—the unsettling of established perceptions about the value of human life.

A requirement of record and opinion imposes only a slight burden on the hospital; someone can take notes and write a summary of the decisionmaking process.⁷² To prevent infringement of privacy, all identifying features of records and opinions can be removed. Another possibility is simply to destroy them after some period of time. But there would be significant advantages in retaining them as a source of information for future decisionmakers and representatives.⁷³ They would promote uniformity in decisionmaking and public confidence in the basic fairness of the process.

One danger of releasing records and opinions for study is that of exposing a body of decisions in an area which people find unsettling. Given that many of our received values deny the possibility of ranking the worth of individual human lives, it would conceivably be safer to conceal the process of decision from the public. But increased public awareness promises its own rewards. It permits individuals to bring a wide range of criticisms and suggestions to bear on the process. The understanding gained from widespread debate may well bring about increased or more efficient spending on medical resources.⁷⁴

71. In the context of the allocation of scarce medical resources, there are several conceivable forms of recourse: (1) applying for resources at other institutions where one might expect to fare better under the evaluative system; (2) complaining to hospital allocation supervisors if one feels that there has been a mistake or other abuse; (3) making a similar complaint to state health officials; and (4) seeking judicial relief under 42 U.S.C. § 1983 (1974) for possible violations of due process, equal protection or other constitutional rights.

72. Cf. *Gagnon v. Scarpelli*, 411 U.S. 778, 786 (1973); *Morrissey v. Brewer*, 408 U.S. 471, 487 (1972).

73. See Calabresi, *supra* note 2, at 400-03.

74. More efficient spending does not necessarily imply increased spending on scarce resources. Certain preventive measures, for example, may ultimately save more lives.